State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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New Number: 603-271-9200

NICHOLAS A. TOUMPAS
COMMISSIONER

April 30, 2012

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, NH 03301

Dear Governor and the Honorable Executive Council:

I want to thank you for providing the NH Department of Health and Human Services the opportunity to provide additional information about the pending contracts for the Medicaid Care Management Program.

We know that there have been a number of questions posed to you by various stakeholders on different aspects of the contracts. We have thoroughly reviewed the questions and have responded specifically to those that can be answered at this time. There are other questions, however, that are subject to pending litigation that we are unable to address. There are other areas that stakeholders have raised questions or concerns, which we have reviewed and will factor those into our review of the managed care organizations' readiness to begin the new program.

In addition to the responses, we have included the outline for the process that we will be using to develop what is known as Step 2 of the program, which includes the long-term care services and supports.

The Department will also set up an "advisory council" composed of what I would call "non-stakeholder stakeholders." These would be individuals that provide a perspective beyond that represented by a provider association or advocacy group. As we have not received agreement from those organizations I am targeting, we are not ready to release the names at this time.

We remain committed to continuing to provide information as the State embarks on this new way of delivering and paying for critical services for our Medicaid population and look forward to working with you to finalize the procurement process.

Sincerely,

Nicholas A. Toumpas
Commissioner

Enclosures

State of New Hampshire
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NICHOLAS A. TOUMPAS
COMMISSIONER

FAMILIES AND CONSUMERS INVOLVED WITH DEVELOPMENTAL SERVICES: NEXT STEPS

1. On Sunday, May 6th at the annual Family Support Conference the Commissioner will discuss the status of the State's Care Management Program. Associate Commissioner Nancy Rollins will be serving on a panel discussion at which time she will provide information on the next steps for engaging families and consumers in the implementation of the new program (Step 1) and describe the process for family and consumer involvement in the design of the long term care services care management model (Step 2).

2. Following a May 9th decision by the Governor & Council, the Department will schedule a meeting with the statewide Family Support Council. This will be a follow-up to the May 6th Conference presentation and serve as an additional opportunity for family members to discuss their recommendations for next steps.

3. The Department will conduct a series of 10 facilitated forums in the late spring to early summer to discuss care management generally and Step 1 implementation specifically. The Department will encourage and seek volunteers to participate in Step 2 design. While focused on persons served through developmental services, all population ages and disabilities–children [0-21], adults [22 – 64] and seniors will be invited to participate

Step 2 Design: Consumer, Caregiver, Providers, Stakeholders and Advocates Involvement

4. The Department will conduct a second series of 10 facilitated forums in the late summer to early fall to elicit consumer and family feedback specific to the design of Step 2. Forum invitees will be all encompassing of the developmental, physical disability and long term care communities and will include consumers, family members, providers, Area Agencies, subcontractors and advocates.

5. Based on feedback from the forums, and feedback from the previously conducted Long Term Care Consumer forums, the Department will develop a series of work groups related to Step 2 design and implementation. Separate work groups will be established for the following three populations: children [ages 0-21]; adults [ages 22-64] who have disabilities; and seniors [65 +]. Work group participants will include consumers, family members, providers and advocates. Additional work groups may be established to focus on identified areas such as program design and quality outcome measures.

6. The Department will create three advisory groups by population for Step 2 design and implementation. The primary purpose of these advisory groups will be to review and provide input on the deliverables produced by the groups identified above in Section 5

CARE MANAGEMENT PROGRAM: RESPONSES FOR GOVERNOR & COUNCIL
April 30, 2012

(1)(12) Do the rates include profit caps or medical loss ratios?

Both profit caps and medical loss ratios were included in the assumptions that resulted in the actuarial certified rates. The key factors in determining the final rates, which were submitted to and approved by the Fiscal Committee of the General Court, were prior years' actual cost experience in New Hampshire, projections of costs of maintaining the current fee-for-service (FFS) payment system, assumptions of reductions in cost through implementation of care management, and contract negotiations, while at the same time ensuring actuarially soundness of the rates. Using this comprehensive approach to reach a per member per month (PMPM) rate, rather than focusing on specific Managed Care Organization (MCO) operational and financial components such as medical loss ratio and profit caps, provides a sound basis to implement the program.

The cost of the care management program will be based on the number of Medicaid eligible members multiplied times PMPM rate of the contract. The PMPM rate does not reflect an individual cap on expenses. The only cap that exists is between the State and the MCO. The PMPM rate, which is the same for all three MCOs, is based on an actuarial analysis provided by an independent actuary retained by the State.

Each of the 22 rate cells, which separated the Medicaid population into 22 groups based upon age and other factors, were calculated based on historical NH Medicaid FFS cost and were then trended by the actuarial consultants to project future Medicaid costs if the state continued on the current FFS model. Each rate cell reflects an average cost over time, or PMPM, based upon the prior history of the members of that group. MCOs need sufficiently large membership to average out the high and low cost members. The prior history of members can be used to adjust the monthly payment, following the calculation provisions of contract. The contract allows MCOs with complex populations to be paid more than those with comparatively healthier populations – this is called "risk-adjustment" and is a process DHHS will carry out on an annual basis with actuarial consultants. This risk adjustment ensures that MCOs will not discriminate against members based upon health status. Utilization and other assumptions were applied by the actuaries to develop the projected reduced costs of providing service to the state's Medicaid population through care management Included in this is the risk adjustment process to support more complex healthcare issues. Through this actuarially sound process, required by the federal Centers for Medicare and Medicaid Services (CMS), DHHS developed the PMPM rate negotiated with the MCOs.

Constant throughout is the foundational requirement that quality will be maintained and/or improved for the vulnerable members of our population in the Medicaid program.

(2) Should we have the MCOs follow a pre-established Bill of Rights?

The MCOs are subject to the state law, RSA 420-B:8-m requiring Health Maintenance Organizations (HMO) to provide copies of the Patients' Bill of Rights, RSA 151:21, to new members.

In addition, the DHHS has put strong emphasis on the quality and effective delivery of Medicaid services in the contracts with the MCOs. As part of that approach, Section 15.3 of the contract requires the MCOs to have written policies regarding member rights as required by federal regulation.

(7) What experience do the MCOs bring that indicates they can manage care for individuals with developmental disabilities?

The key factor is whether the MCOs have demonstrated their abilities to take a whole-person approach to their members to address the social determinants of health, which go far

beyond just medical or developmental disability needs. DHHS believes the MCOs have demonstrated this capacity. Each of the MCO's has a wealth of experience in managing health conditions of members. The process includes determining the clients' needs, understanding resources available to meet those needs and delivering services that both maximize the client's ability to function independently and minimize the cost to the taxpayers. This is in concert with the mission of the Department "to join communities and families in providing opportunities for citizens to achieve health and independence."

Each of the MCOs has experience in other states dealing with the needs of diverse populations. Managing and coordinating care for the elderly involves different types of services and providers than those needed by newborns, the blind or disabled. In each case, the MCOs are required to have knowledgeable staff to understand the needs of its members in order to best manage their care. They must be able to provide information on benefits, and help the member access covered services. Through comprehensive care management that considers members' care from a holistic rather than segmented approach, the MCOs are expected have the ability and flexibility to develop innovative approaches to the individuals served in Medicaid programs that are not available through the fee-for-service Medicaid program.

In Step 2 of the Medicaid care management program long-term services are included to provide a holistic approach to care rather than to continue to deliver them in a separate or fragmented manner. In Step 2, we will take advantage of the MCOs' experience in managing care in other states and partner with members, their families and providers to integrate medical and support services.

(9) What accountability do the MCOs have to the state? Do we have any actionable guarantees?

There is a significant level of accountability to the State as well as enforcement provisions in the contract. DHHS looks forward to a positive and productive partnership with the MCOs. However, built into the contract are numerous provisions for corrective processes, leading to sanctions, liquidated damages and other legal remedies should the Department need to exercise those protections.

Section 29.2.9 provides for a positive form of enforcement by withholding 1% of each member's capitated payment to support DHHS's quality performance benchmark incentive program. The MCOs can earn back the withheld payments by meeting outcomes-based goals set by the Department annually.

(12) How will the revenue from the MCOs' NH Insurance Premium Tax payment be handled?

The premium tax will be collected and distributed as required under RSA 420-B:17. The Department of Health and Human Services is not involved in the tax assessment, collection, or redistribution process. Ultimately, the Legislature will decide how the revenues will be allocated.

(15) Network Adequacy is determined by CMS at some point before implementation, (either April 1, 2012 or within 30 days of contract approval):
a. Is this sufficient time to develop and contract a provider network?
b. Will any NH agencies also approve network adequacy, either DHHS or the NH Department of Insurance?

a. A sufficient provider network is required before DHHS can roll out the program. With the adjustment in the timeline, there is adequate time for provider network development to take place. CMS will review the contracts once they are fully executed, which requires the approval of Governor and Council. Once the contracts are submitted to CMS, the agency will review them to

verify that all federal laws, rules and regulations are adequately reflected in the agreements. Those federal requirements include provision of minimum standards for network adequacy. In developing the contracts, DHHS included those required by of the NH Insurance Department (NHID). DHHS and NHID both serve a role in overseeing the MCOs and the implementation and operation of the program. (See NHID Bulletin Docket No. INS No. 12-015-AB, April 4, 2012.) DHHS will be responsible for approving network adequacy, which is a critical implementation requirement. The program will not begin until network adequacy and other components of readiness review requirements are met.

(19)(83)(107) What are the staffing requirements for MCOs?

Section 6 of the contract details the MCOs' staffing requirements. Among the requirements, MCOs must have staff committed to New Hampshire's program with an on-site presence in several areas, including behavioral health, developmental disabilities and special needs (Section 6.1.2). The Department will be reviewing the staffing plans and monitoring their effectiveness as it moves into Step 2 of the program.

The MCOs also must operate a New Hampshire specific call center (15.4.1) and a toll-free line for provider inquires with personnel who are knowledgeable about the MCO's plan in New Hampshire (Section 19.2.13)

(23) Why are the Federally Qualified Health Centers' (FQHC) and Rural Health Centers (RHC) rates guaranteed but not the Community Mental Health Centers'(CMHC) rates?

Federal regulations require FQHCs and RHCs to be paid using a certain methodology. The MCOs are expected to negotiate rates with all other providers.

(25)(32)(33)(34) Are MCOs accepting responsibility for non-members such as family members?

No, the MCOs are not accepting responsibility for family members who are not eligible for the NH Medicaid program.. The Department does, however, recognize the importance of families' role in the wellbeing of Medicaid members. and Sections 10.1.2 and 10.1.3 of the contract give recognition to the critical role that families and providers serve in the system of care model.

(30) The contract requires that the MCO will ensure transportation is not a barrier. Operationally, how will this be defined and measured? What are penalties for not achieving goal of transportation not being a barrier to any MCO member?

Within the contract in Section 10.4 non-emergent medical transportation is defined. Through the reporting as defined in this section and the member satisfaction survey we will verify that the MCO is in compliance with the contract requirements.

(70) Regarding Section 27.1.1 --- Currently clean electronic claims submitted to EDS are paid in 10-12 days. Given that Medicaid is the largest source of revenue for CMHCs and the fact that the State regularly collects and reports out on financial indicators including days of cash on hand for each center, what analysis was done by DHHS to determine the impact of delaying payment by 2 to 3 times the length of time from claims submission to payment, if this contract language is implemented? This would have a significant and harmful impact on safety net providers. The Endowment for Health funded three reports that clearly indicate the fiscal fragility of the CMHCs, CHCs and critical access hospitals. Furthermore, RSA 415:6-h for individual plans and RSA 415:18-k for group plans currently requires payment of clean electronic claims within 15 days. Why would the State double this, as well as the length of time to request additional information and/or deny the

claim, for MCOs, for any reason other than to allow them more time to invest the float to the detriment of safety net providers and some of the state's most vulnerable residents?

Current state rules applying to Medicaid FFS claims match the federal payment processing standards in 42 CFR 447.45. Those are: 90% of clean claims must be paid within 30 days and 99% must be paid within 90 days.

The contract with the MCOs, however, sets higher standards than the FFS and federal requirements. The contract raises the percentage of clean claims that must be paid in 30 days to 95%, rather than 90%. In addition, the contract requires 100%, rather than 99%, be paid in 60 days, rather than 90.

(The RSAs cited related to Accident and Health Insurance and commercial managed care products, and do not apply to Medicaid FFS or Medicaid Managed Care.)

Furthermore, while the contract sets minimum payment standards, it does not preclude providers and MCOs from agreeing to even more favorable terms.

(72) Regarding Section 27.1.5.1, why does the MCO contract contain a definition of "clean claim" that is different than the one that already exists in state statute? See RSA 415:18-k(a).

The contract provides stricter payment processing requirements than both the current FFS rules and federal requirements.

(74) Now that we know there's a delay in the implementation of the care management program, what are the realistic timelines for enrollment, program start and the start of Step 2?

The Department has made great effort in meeting the deadlines that were set by the Legislature. However, as we have indicated all along, there are factors that are outside the purview of the Department that impact the schedule. As such the current timeline for enrollment and program roll out is planned to be completed by the end of 2012. DHHS will continue to apply its resources to getting the program up and running as soon as possible while at the same time taking great care to make sure that the transition goes as smoothly as possible. The contracts, if and when approved by the Governor and Council, have to be approved by the Centers for Medicare and Medicaid Services (CMS). CMS also has to approve the capitated rate and the Medicaid State Plan Amendment prior to the start of the program. Other factors include, but are not limited to the MCOs' ability to develop their infrastructures, the Department's ability to establish the infrastructure it needs to assist Medicaid members in their enrollment into the new program and to have its information technology systems connect with the MCOs'.

The Department will be working with the MCOs, CMS and stakeholders to adjust the timelines as appropriate.

(90) Section 7.2.2 asserts that the Department is relying on the RFP narrative responses by each of the MCOs as commitments regarding how they will deliver and manage the New Hampshire Medicaid Program. Are these narrative RFP responses, which were applications to win the contract and not commitments, appropriate documents for the Department to rely on with respect to establishing benchmarks or standards relating to program management and program delivery? Are they sufficiently specific and detailed? Is this common practice within contracting for Medicaid Managed Care arrangements? Are the representations made in the RFPs accurate? Have the representations made within these RFP narrative responses been verified in any way by the state prior to executing these contracts?

In developing the contracts, DHHS worked closely with the Attorney General's Office to ensure the agreement is legally binding. The MCOs are accountable for all representations and warranties included in the agreement.

Moreover, in order to enter into the agreement, each MCO was required to be licensed by the NH Insurance Department to operate within the state. NHID has conducted solvency and financial reviews before issuing the required licenses to the MCOs.

(96) What is DHHS's role in ensuring that all the MCOs' requirements specified in the contracts are met?

Federal regulation requires that the State retain its primary responsibility for administration of the Medicaid program. As such, DHHS remains the primary oversight agency for the Medicaid Care Management program. Each of the Department's Medicaid administration bureaus will monitor MCO performance to ensure the Medicaid program remains in compliance with Federal and State regulations.

However, the NH Insurance Department will oversee licensing and solvency requirements and other relevant insurance laws and regulations. (See NHID Bulletin Docket No. INS No. 12-015-AB, April 4, 2012.)

The contract requires DHHS approval of all critical policies, procedures and plans of each MCO regarding implementation and operations. Member enrollment, services, communications and quality programs are of primary concern.

DHHS, advised by the Attorney General, strove to develop an RFP and contract that lay out the levels and quality of service to be provided to members while also maintaining an approach that allows for and encourages innovation from the MCOs on how they meet the program goals.

Once contracts are approved, DHHS can begin working with the MCOs to develop the Implementation and Program Management Plans that will be integrated into the contract as Exhibits K and L. These plans will include the steps, deliverables and timing of what must happen before the "go live" date and how each MCO and DHHS will manage the program. In keeping with Department goals, and the requirements of RSA 125, two readiness reviews will take place to ensure that there will be no reduction in the quality of care of services provided to enrollees and the current quality of care will be maintained or increased.

DHHS looks forward to a positive and productive partnership with the MCOs. However, built into the contract are numerous provisions for corrective processes, leading to sanctions, liquidated damages and other legal remedies should the Department need to exercise those protections.

(98) How will elected officials and the public be kept informed of all the MCO's performance metrics?

DHHS has been reporting performance/quality metrics on the fee-for-service program for over six years. Reports have been published on the DHHS website, sent by email and US Postal mail to elected officials and stakeholders and presented as part of the biennial budget process. With this activity serving as a foundation, DHHS will be developing a centralized quality improvement and reporting website and using social media to announce when new reports are published. Detailed reports as well as "dashboard" reports will be available. Definitions of measures and methodologies will be documented. Meetings of the Legislative Health and Human Services Committee will serve as a venue for routine reporting on all aspects of the care management program. In addition, the Social Security Act requires that states that operate Medicaid managed care programs provide for an external, independent review of their managed care organizations. The Department will be contracting with an External Quality Review Organization (EQRO) to perform this function.

(103) What is the Consumer Assessment of Healthcare Providers and Systems Survey?

The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services. The survey has become the national standard for measuring and reporting on the experiences of consumers with their health plans. A version of this survey is conducted in almost every state. NH Medicaid will be conducting a baseline survey shortly.

(105) How is a Health Home different than a Medical Home?

A health home is defined in Section 2 of the contract in the Glossary of Terms & Acronyms. It goes beyond a medical home model to encompass the coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses (Section 10.2.4). The state law establishing the care management program requires all Medicaid members to receive their care through a medical home. The Department is carrying out this requirement by requiring the MCOs to ensure that each member has access to an ongoing source of primary care (10.2.1).

(106) What are the Implementation and Program Management Plans, and how will they be evaluated and approved?

The Implementation and Program management Plans are both defined in the Section 2.1 Glossary of Terms. Section 7.4 indicates the DHHS approval required for the Program Management Plan. Section 7.6 addresses the submission and contents of the Implementation Plan. DHHS has approval and oversight authority for both plans. Both are required elements of the readiness review process (Section 7.6.4). DHHS may require a corrective action plan for any deficiencies regarding both plans, and may invoke liquidated damages (Section 32.7.1) if an MCO does not comply.

(110) What is the Payment Reform Plan?

The Payment Reform Plan, like the Quality Incentive Program, is another 1% withhold of capitation rate payments which would be paid to the MCOs based on performance. In the case of the Payment reform Plan, each MCO must submit a yearly plan to engage its provider network in health care delivery and payment reform activities, subject to review and approval by DHHS.

The plan must contain information on the anticipated impact on member health outcomes of each specific activity, providers affected by the specific activity, an implementation plan for each activity and an implementation milestone to be met by the end of each year of the Agreement for each activity.

DHHS will withhold one percent (1%) of MCO capitation payments in each year of the Agreement under the Payment Reform Plan. The MCO will earn a pay-out of that withheld amount if it meets the implementation milestones described in the Payment Reform Plan.

(111) How will DHHS ensure that the Grievance and Appeals Process is fair and that all rights of patients and providers are maintained?

Section 17 of the contract carefully lays out the grievance and appeals process from the initial approval by DHHS of MCOs' policies and systems.

Members must be informed of their right to a state fair hearing. Providers may assist a member and act on the member's behalf.

Members have a right to initiate a grievance for issues that may include, but are not limited to the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. If a member is not satisfied with the outcome, the member has a right to a state fair hearing. As is currently the case, federal law (42 CFR 438 Subpart F) and NH rules (N.H. Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure) would continue to apply to ensure that the rights of members and providers are maintained.

(112) How does the standard for geographic accessibility compare to national standards, and how will DHHS ensure sufficient adequacy?

In order to ensure the provision of services to members, safeguards are included in the managed care contract regarding both the geographic distance to providers and the timely access to service delivery.

Geographic access standards (Section 18.2.1) indicate in miles and times the maximum travel distances for various provider categories. Timely access to service delivery (Section 18.3) requires: availability of medically necessary services 24/7; minimum hours of operation of providers; and minimum waiting times for appointments for transitional care, preventive and routine care, urgent and emergency care, and behavioral health care.

In addition, there are provisions for members' access to Level I and Level II trauma care and specialty hospital services as well as out-of network providers. Members are also entitled to a second opinion, and can choose their health providers to the extent possible and appropriate.

Members may choose their own primary care provider in any of the MCO networks, or the MCO will assist the member in choosing a PCP appropriate to the member's prior history and current health care needs.

Network adequacy is a critical implementation component that will be a focus of the readiness reviews (Section 7.6.3.1.2)

These access requirements are modeled on federal regulations, which will be applied by CMS in its review of the contract, and NH Insurance Department rules.

(120) 1. More details are needed on the Quality Assessment and Performance Improvement (QAPI) Program.

In addition to the contract language, information on the Quality Assessment and Performance Improvement (QAPI) program can be found in the Code of Federal Regulations, 42 CFR 248.200, Subpart D-Quality Assessment and Performance Improvement.

(121) How will the MCO develop and conduct the minimally required four performance improvement projects per year?

The MCOs will develop and conduct the projects in collaboration with their member and provider advisory boards after approval by DHHS. DHHS and the MCOs will meet quarterly to discuss quality related initiatives and how those initiatives could be coordinated across the MCOs. Additional information can be found in the NH Medicaid MCO contract, Section 20.1.1 and 42 CFR 438.240.

(122) What are the clinical practice guidelines referred to in Section 20.2.4, and how will they address utilization management, member education, and notice of coverage decisions?

Section 21 of the contract addresses utilization management, medical necessity and notices of coverage determinations. This section complies with the requirements defined in federal law (42 CFR 438.210) and NH law (RSA 420-E:4.)

Further, the contract requires that the MCOs' written utilization management policies, procedures, and criteria describe the categories of health care personnel that perform utilization review activities and where they are licensed. Such policies, procedures and criteria shall address, at a minimum, second opinion programs; pre-hospital admission certification; pre-inpatient service eligibility certification; and concurrent hospital review to determine appropriate length of stay; as well as the process used by the MCO to preserve confidentiality of medical information. (Section 21.1.6)

The MCO's written utilization management policies, procedures, and criteria must be developed with input from appropriate actively practicing practitioners in the MCO's service area, updated at least biennially and as new treatments, applications,

and technologies emerge, developed in accordance with the standards of national accreditation entities, based on current, nationally accepted standards of medical practice, and evidence-based. (Section 21.1.7)

Requirements for timely coverage determinations made in a time period appropriate to the medical circumstances of the member are detailed in Section 21.3.

(126)(24)What is the process by which DHHS will ensure there are effective, secure, and accurate interfaces with the state's eligibility system, provider enrollment systems and other relevant systems, and that PHI (personal health information) is protected?

Section 25 of the contract includes detailed MCIS requirements that apply to the MCOs and subcontractors. Section 25.5.12.2 specifically addresses personal health information protection and segregation, and Section 25.5.12.4 addresses HIPAA compliance.

Technical MCIS requirements in Sections 22.5.3 – 22.5.12 address functionality, access capability, systems operations and support, telecommunications and network infrastructure, data transmission, web access, and contingency planning.

DHHS and the Department of Information Technology (DOIT) will conduct systems readiness reviews to ensure all systems required to support implementation of the program are compliant.

(127) What is a Pharmacy Lock-in Program?

A pharmacy lock-in program identifies and manages Medicaid members who demonstrate abusive patterns of obtaining prescription medications. The program restricts or "locks" them into one primary pharmacy to obtain all prescription medications. This program already exists in the current fee-for-service program.

(128) What protection is there to prevent discrimination against certain types of providers? e.g. optometrists.

Federal law prohibits an MCO from discriminating against providers based on their scope of license or certification. Sections 19.2.19-.20 use the federal language which goes on to clarify that while MCOs may not discriminate for participation, reimbursement, or indemnification, they are not required to contract with providers beyond the number necessary to meet the needs of its members, nor precluded from using different reimbursement amounts for different specialties or practitioners, or from establishing measures to maintain quality of services and control costs. (See 42 CFR 438.12(a))

In addition, the contract contains provisions to ensure that provider enrollment, credentialing, model contracts, and other materials must meet federal regulatory requirements and be approved by the Department.

Q. (BH Qs) What is the relationship between the MCOs and providers?

The MCOs are required to establish a statewide network of services to provide Medicaid covered services for their members. To build their networks, MCOs will contract with community-based providers. The terms and conditions will be defined by the two parties. At the same time, the MCOs must adhere to the requirements within its contract with the Department.

Q. (BH Qs) Does eligibility for Medicaid change under the new care management program?

There will not be any changes in Medicaid eligibility, including how it is determined. However, DHHS continues to work on its "Front Door Access" project to further streamline both the eligibility and member services functions. The MCOs involvement begins once a member has been deemed eligible for Medicaid and is enrolled with a MCO.

Q. (BH Qs) Doesn't the new program duplicate functions and services already in place?

No. The new program is designed to coordinate and integrate services, not duplicate them. It is expected that the MCOs will leverage existing resources when appropriate.

Q. How will the MCO develop and conduct the required four performance improvement projects per year?

Although they have some discretion, the MCOs have to support and comply with the Quality Strategy for the NH Medicaid Care Management Program, they must work in collaboration with providers and they must also provide mechanisms for member and provider advisory boards' participation in the activities (Section 20.1.1). All of the MCO efforts are subject to DHHS approval.

Q. What is full risk managed care? In looking at the per member per month rates that will be paid to the MCOs, it seems as if I fall into a certain category, I'm only going to be able to receive up to a certain amount of care but I may need more.

These rates can be seen as those charged by insurance companies—the per member per month rate takes all of the members in one category into account—those who need a lot of services and those who need much fewer. This is one of the reasons why it's important to have all populations included in the care management program so that the risk can be spread out among the groups. So again, there is no cap for individuals—the only cap is between the state and the MCO. The MCO cannot establish a dollar cap or charge individuals.*Please see the attached document to learn more about risk-based care management

Q. How to the managed care companies plan to establish "risk corridors" with providers?
As part of the Payment Reform Plan required in Section 9 the contract, MCOs could propose to establish risk corridors with providers. The Payment Reform Plan must be approved by the Department. DHHS will withhold 1% of MCO capitation payments in each year of the Agreement and the MCOs will earn a pay-out of the withheld amount if it meets implementation milestones (Section 9.1.3)

Q. Are any of these three managed care companies accredited by the National Council of Quality Assurance?
The three MCOs' plans in other states are accredited by either the National Council of Quality Assurance or URAC, another nationally recognized accreditation organization.